Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES

PLANNED ACTION NOTICE
MEDICAID SERVICES

CLIENT/APPLICANT NAME AND ADDRESS

REPRESENTATIVE NAME AND ADDRESS

DDD has made the following decision(s) regarding your services or request for services.

This decision is effective _____

REASON FOR DENIAL, REDUCTION, OR TERMINATION OF SERVICE

The list references the reason numbers below:

1. You are not eligible for this service.
2. You do not have an assessed need for this service.
3. You cannot receive or use the service in the manner you requested.
4. You do not have an assessed need for the amount of service you requested or previously had.
5. The service is available through other resources.
6. You are no longer eligible for the categorically needy Medicaid program.
7. You or your representative requested this decision.

DECISION

SERVICE	DECISION	REASON	AMOUNT
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	

DECISION (CONT.)			
SERVICE	DECISION	REASON	AMOUNT
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	
SERVICE	DECISION	REASON	AMOUNT
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	
SERVICE	DECISION	REASON	AMOUNT
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	
SERVICE	DECISION	REASON	AMOUNT
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	
SERVICE	DECISION	REASON	AMOUNT
	☐ Reduced	WAC 388- Reason #	From: To:
	☐ Denied ☐ Terminated	WAC 388- Reason #	

ADDITIONAL COMMENTS

YOUR APPEAL RIGHTS

You have ninety (90) days from receipt of this notice to request an administrative hearing to appeal this action.

- If you are currently receiving this paid service from DDD and want the service continued during your appeal, you must file your request for an administrative hearing by _____.
- If you choose to continue this paid service and the final decision upholds the department's action, you will be responsible to repay up to 60 days of paid services.
- If you do not want your paid services to continue, contact:

_____ at _____

CASE/RESOURCE MANAGER | TELEPHONE NUMBER

You have the following rights:

1. To be represented (you may be eligible for free legal assistance);
2. To request a copy of your file and all information reviewed by DDD to make its decision;
3. To submit documents into evidence;
4. To testify at the hearing and to present witnesses to testify on your behalf; and
5. To cross examine witnesses testifying for the department.

A form for requesting an administrative hearing is enclosed.

QUESTIONS

If you have questions about this decision or appeal process, please contact:

NAME	TELEPHONE NUMBER	LOCAL OFFICE

Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

PLANNED ACTION NOTICE
DDD MEDICAID SERVICES
REQUEST FOR HEARING

per Chapter 388-02 for DSHS hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME | TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARING (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following service decision by the Division of Developmental Disabilities (DDD):

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS OF PERSON REQUESTING HEARING	CLIENT ID NUMBER	
CITY STATE ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ **MESSAGE PHONE**	

I was notified of the decision on: _____ by: _____
DATE DSHS OFFICE NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ **Yes** ☐ **No** Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
ADDRESS CITY STATE ZIP CODE		

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ **Yes** ☐ **No**

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing, follow the instructions in the Notice of Hearing that will be mailed to you by OAH.

WAC Reference for Medicaid Services Planned Action Notice

SERVICE	WAC	REASON
All Exceptions to Rule	388-440-0001(1)	ETR Criteria
	388-106-0815	Eligibility
Medicaid State Plan Services		
Adult Day Health	388-106-0810	Definition of ADH
Private Duty Nursing	388-106-1010(d)	PDN service and requirement for 4 hours of continuous nursing
	388-106-1010	Eligibility
	388-106-1030	Limitations and restrictions
Medicaid Personal Care	388-106-0210; 0020	Eligibility for MPC
Adult In-Home MPC	388-106-0125; 0130; 0135	In Home: Number of hours Maximum: Number of hours
	388-106-0220	Requirement for annual redetermination/reassessment
AFH/ARC MPC	388-106-0080; 0115	Amount of services
	388-106-0210	Payment rate for AFH/ARC
Child In-Home MPC	388-106-0213; 0130; 0135	Age guidelines

INSTRUCTIONS FOR MEDICAID SERVICES PLANNED ACTION NOTICE

Notification Requirements

1. A Planned Action Notice must be sent when a service(s) is reduced, denied, or terminated.
2. A request for a specific service can be oral or in writing. A denial of either request requires a Planned Action Notice.
3. All decisions are documented in the client's CARE Service Episode Record.
4. The Planned Action Notice must be sent within 5 working days of the decision date.
5. The Planned Action Notice is addressed to the client regardless of age and a copy sent to their representative per WAC 388-825-100. Use the following order to determine who represents the client:
    - A parent if the client is under the age of eighteen (18);
    - The guardian or other legal representative;
    - Other relative;
    - Other person identified by the client;
    - An advocacy agency.

Completing the form

1. The effective date
    - The effective date of a reduction or termination is always the last day of the month. It is a minimum of 10 working days and a maximum of 90 days from the date the Planned Action Notice is mailed to the client.
2. Services: Choose the service from the attached list of services and WAC references.
3. Decision: Identify the appropriate decision.
4. Reason:
    - Insert the WAC number(s) that give the legal authority for the decision.
    - Insert the corresponding number of the reason(s) listed on the Planned Action Notice for the decision.
5. Amount:
    - Amount and unit of service required for Reductions.
    - Example: Reduced "From" 100 hours per month "To" 80 hours per month.
6. Page two is optional. Use if there are more than two decisions.
7. Instructions for completing a translated form:
    - Enter the information in English
    - Identify each service with a number if there is more than one.
    - Write the number next to the corresponding reference line on the Services/WAC chart and highlight the WAC reference and reason.

Appeal Rights

1. Insert a date in the first bulleted statement ONLY if this is a reduction or termination of an existing service.

2. To calculate the date in the first bulleted statement:

   - Count 10 days from the date the notice is mailed. The 10th day must be a working day.
   - Extend to the end of that month.

   Examples:

   1. The notice is completed October 10th with anticipated mailing October 11th.
      - Ten (10) days counting October 11th is October 20th.
      - The last day of the month of the 10th day is October 31st.

   2. The notice is completed October 20th with anticipated mailing October 23rd.
      - Ten (10) days counting October 23rd is November 1st.
      - The last day of the month of the 10th day is November 30th.

3. Case/Resource Manager name for terminating paid services during an appeal is the CRM responsible for authorizing the client's paid services.

4. The name at the bottom of the form will be determined by regional authority.